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NCA
OFFICE OF INTEGRATION
NEWSLETTER

SERVING AS THE VOICE OF THE OFFICE OF INTEGRATION

in·te·gra·tion | in-ti-**grey**-sh*uh* n |

the combining and coordinating of separate parts or elements into a unified whole

MG Schoomaker named *Commander* of Walter Reed

In the wake of a series of articles in which the Washington Post revealed issues with the medical hold and outpatient facilities at Walter Reed, Secretary of Defense Robert Gates named Maj. Gen. Eric Schoomaker (pronounced: Skōō-māker) the commander of Walter Reed Army Medical Center (WRAMC). A seasoned Army physician, MG Schoomaker will also serve as the commander of the North Atlantic Regional Medical Command (NARMC).

Acknowledged by Army Vice Chief of Staff, General Richard Cody, as having the "right blend of leadership, professional expertise, and personal experience" necessary for both positions, MG Schoomaker assumes command of Walter Reed as a highly esteemed leader and physician throughout Army medicine.

His resume reflects a diverse range of command experience which includes: Command of 30th Medical Brigade headquartered in Heidelberg, Germany, Command Surgeon for the U.S. Army Forces Command (FORSCOM), Commanding General of the Southeast Regional Medical Command and Dwight David Eisenhower Army Medical Center, and most recently the Commanding General of U.S. Army Medical Research and Material Command at Fort Detrick, Md.

Born into an Army family, MG Schoomaker has an undying commitment to the men and women who wear the uniform. The allegiance he has is certifiably familial, as his brother, General Peter Schoomaker, serves as the Army's 35th Chief of Staff.

> *...integration of the medical centers is "still the right thing to do."*

Amid countless congressional meetings and interviews with both the local and national press during his first week in command, MG Schoomaker made time to meet with the commanders of the military treatment facilities within the National Capital Area. On Tuesday, March 13 at Dewitt Army Community Hospital at Fort Belvoir he offered his vision on the integration of Walter Reed Army and National Naval Medical Centers.

MG Schoomaker emphatically stated to all in attendance that the integration of the medical centers is "still the right thing to do". To further emphasize his perspective, the two-star general explained comprehensively that "form should always follow function". The guidance he offered the senior leaders left no doubts that the plans to functionally integrate the medical centers will remain his highest priority. ■

INSIDE THIS ISSUE:

What's Happening?

The Status of Integration– *Now*

The man considered to be the point man for the integration movement in the National Capital Area took time out of his demanding schedule one afternoon to meet with us at his office on the Bethesda campus. In this hour long interview he discussed the status of integration and the impact of the Washington Post series on the Walter Reed Army Medical Center. We got an inside look at one man's dedication and loyalty to the integration movement.

COL Thomas Fitzpatrick, Director of the Office of Integration, well-known for his quiet, professional demeanor unequivocally reaffirmed his commitment and dedication to integration as still the "right thing to do".

OOIN: In our interview with CAPT Wade, as the newly appointed Director of the Integration Steering Committee (ISC), he outlined for our readers what he foresaw as be the major milestones this committee needed to achieve within the next 30 days and throughout the year.

With all that's currently going on in the press, do you anticipate that what CAPT Wade shared with us last month will change in any way?

TF: The major milestones that CAPT Wade outlined should remain intact, even with the media attention to the BRAC process. Over the next 30 days, the ISC subcommittees will continue to work to produce a clearly defined vision of their tasks for the coming year. That's why we've given them the opportunity to describe one goal with clearly stated tasks, timelines, and action agents. After the review of the initial goal, the committees by 28 April will complete this for each of their objectives. They should have all of their tasks for meeting their goals outlined, to include due dates as well as identifying who is responsible for each task. Comments that CAPT Wade made last month are in line with these goals and objectives.

> "... integration of military health care in the NCA should continue *regardless* of what occurs with BRAC."

OOIN: So with that in mind, what would you emphasize that the committees need to be targeting?

TF: I believe the subject-matter experts, who are members of those committees, have identified their target objectives. The committees considered recommendations from the Deputy Commanders for Integration and the Office of Integration. Each one of the subcommittees then formulated a list of objectives and tasks. These were then reviewed by the Deputy Commanders for Integration (DCI). The DCIs acknowledged the sub-committee's hard work, but were concerned that the sub-committees may have been too aggressive and possibly bitten off more than they could actually handle for the upcoming year. They suggested that the groups prioritize their objectives and address the most important issues.

OOIN: So what I'm hearing you say is that you feel confident that since these tasks and objectives are coming from the subject-matter experts who do the work from day-to-day that you feel comfortable with where we're headed in the next year. Is that a fair assumption?

TF: Yes, definitely.

OOIN: In the January edition we featured Army Colonel Doukas as the Chief of the Integrated Department of Orthopedics and Rehabilitation at Walter Reed and the National Naval Medical Center.

What clinical integration activities can our readers expect next?

TF: We have nearly completed the selection of Colonel Doukas' service chiefs. These names should be announced within the next couple of weeks. In the meantime, they've been comparing the processes between the services at Walter Reed and NNMC, so that they can do things the same way. The services should have the same dashboard that evaluates if they're meeting their goals. The departments and services should function the same at each of the facilities. The appointing and scheduling process will be the same. When someone walks in the door they will be greeted the same way and checked in the same way. No customer, internal and external, and no providers should be able to tell the difference between care provided at either facility.

OOIN: The Information Management sub-committee chaired by COL Rowland, the Director of the Department of Information Management (DOIM) at Walter Reed, developed and proposed a multi-million dollar plan to integrate the National Capital Area (NCA) network and domain.

Until the monies are approved to green-light COL Rowland and his team's plan, what immediate steps are being taken to assist and support our interns and residents who commute back and forth between the medical centers with accessing their electronic mail accounts at both places? **(Continued on Page 3)**

What's Happening?

The Status of Integration Now (continued)

(continued from Page 2)

TF: This has already been addressed and I believe a good work-around is in place. Each of the services, Army, Navy, and Air Force have reinstated the web-based Outlook. Now, no matter at which military facility the staff or residents are working, they can go to a hospital or clinic computer with their CAC card and access the e-mail account at an alternate facility. I use it myself and find that it works pretty well as a work-around.

OOIN: The challenges currently facing the Military Health System (MHS), as well as the Veterans Health Administration (VHA) have garnered national attention in the media during the past few weeks.

What efforts are being made to partner with the VA to streamline processes, and ultimately improve care to our former and current service-members?

Colonel Thomas Fitzpatrick

TF: We meet with the Washington D.C. VA on a frequent basis to various types of cooperative efforts. Here are a few examples: 1.) We are looking at the use of the VA mail-order pharmacy, so that prescription for patients from any of the military hospitals in the NCA can be refilled using the VA CMOP (Consolidated Mail Outpatient Pharmacy). The CMOP will fill the prescriptions for the patients and mail their prescriptions to them, so they don't have to drive in to the hospital. This will naturally decrease the waiting time for prescriptions at the pharmacies, but also save us approximately a thousand parking spaces a day for all of the facilities throughout the National Capital Area. This will have a significant effect on our parking problems. 2.) We are also looking at how we can better care for the traumatic brain injured patients. The VA is interested in developing a transitional residential facility. It will be sort of a half-way house, when the patients are not quite ready to live on their own, they will remain in a more protected facility. They will also have to complete tasks that would ensure that they were ready to live independently. They have what they call "Easy Street" (a simulation module takes situations that we find ourselves in daily and enhances them to train patients to regain independence), where they go through processes that they would be required to perform on their own. For example, they show them how to order food at a restaurant or pay for food at a grocery store. This will ensure that they are prepared to live on their own. 3.) Another opportunity we're looking at is streamlining the demobilization and evaluation board processes. The plan is to include the VA earlier in the process, so there isn't a big transition once service members leave the military and try to get into the VA. We're planning to begin all of this simultaneously. These are big tasks that will pay enormous benefits to the service members. 4.) The other thing is that as we design the new hospitals, we're looking at the possibility of adding VA Community Based Outpatient Clinics (CBOCs) at the new facilities, at least at Fort Belvoir since there is a high VA beneficiary population in Northern Virginia.

OOIN: Can you give our readers an idea of what is happening in the NCA MHS regarding the inquiries being pursued by the DoDs Independent Review Group (IRG) and the President's commission led by Senator Dole and Ms. Shalala?

TF: I'm not in a position to answer that right now.

OOIN: In closing, what would you like to say to our readers regarding the spotlight that currently has focused attention on the MHS?

TF: I believe that the military healthcare system is an exceptional system. We provide great care to our patients and we will always make sure we continue to do that. We will continue to correct deficiencies that have been brought to our attention. I feel the integration process will allow us to provide the best health care available to our wounded service members, our retirees, and their families. We must continue to optimize the medical assets from all three of the Services to make sure that we're doing the best we can for all of our patients. I also believe that the integration of military health care in the National Capital Area should continue regardless of what occurs with BRAC (Base Realignment and Closure). ■

How's Integration Happening?

Here's an introduction to the Integration Steering Committee

Each week the Integration Steering Committee (ISC), comprised of eight sub-committee chairs seated at the table, meet to progress the integration movement. During these two-hour meetings, the sub-committee chairs discuss the goals, objectives, and tasks that they will implement to achieve integration.

The chairs provide frequent updates to the entire committee, as well as to senior leadership regarding the progress the teams they represent have made towards meeting these objectives. They discuss, as well, the foreseeable challenges that may hinder their team from meeting their goals.

In this forum, the integration of the medical centers is the primary mission at hand. Currently, oversight of the committee is provided by both the Deputy Commanders for Integration (DCI) through the Office of Integration (OI). ■

Sub-Committee	Chairperson
Administrative Services	**Name:** Col. George Small, MGMC **Phone:** 240-857-8009 **Email:** george.small@andrews.af.mil
Clinical	**Name:** COL Greg Argyros **Phone:** 202-782-2351 **Email:** greg.argyros@na.amedd.army.mil
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Health Care Operations	**Name:** COL Dave Jones **Phone:** 202-782-6753 **Email:** david.jones@na.amedd.army.mil
Health Professions Education	**Name:** COL Cathy Nace **Phone:** 202-782-7314 **Email:** mary.nace@na.amedd.army.mil
Information Services	**Name:** COL Frank Rowland **Phone:** 202-782-1060 **Email:** franklin.rowland@amedd.army.mil
Nursing	**Name:** Col John Murray **Phone:** 301-319-8920 **Email:** john.murray3@andrews.af.mil
Research	**Name:** COL Charles McQueen **Phone:** 202-782-6389 **Email:** charles.mcqueen@na.amedd.army.mil

Nursing Staff Offsite Gets *Results*

By: Jan Clark, PAO, Dewitt Health Care Network

In an effort to better prepare her senior nursing staff for the ongoing Base Realignment and Closure (BRAC) and for integration, COL. Patricia Horoho, Deputy Commander for Nursing, Walter Reed Army Medical Center (WRAMC), invited Organizational Development (OD) facilitators for an offsite on January 25 and 26.

The OD team comprised of Teresa Esola and LTC. Jeff Peters, DeWitt Health Care Network (DHCN), Fort Belvoir, hosted the offsite for Horoho's staff. Held in building 52, the offsite was the second in a series scheduled through Horoho and facilitated by Esola and Peters. To say it was enlightening would be selling it short. It was obvious from the beginning that engaging in the event would reap rewards – and participants did engage. As the BRAC and Integration Public Affairs Officer for the DHCN, I had the opportunity of observing the two-day event.

OD Facilitators with nursing team
Photo: Jan Clark

Six members, not available for the initial session in September, met Thursday morning to complete the Spectrum Development Temperament Model. The model is designed to assist people in realizing their natural interaction and temperament styles. Participants completed a 10-part questionnaire, to determine whether they possessed introverted or extraverted interaction styles. Natural interaction style is how a person processes information, whether they talk while thinking or think before talking. Natural temperament style represents the individuals' core needs often illustrated by their unique joys, values and stressors. "What makes you tick and what ticks you off," explained Esola. The style components show how an individual processes information (thinking process) and how they get their energy (energy source).

The next step to discovery is to determine individual temperaments. Born with a natural temperament, individuals are influenced by attitude, behavior and perception. Realizing your "core need" color (temperament), is the first step to learning and developing that core need, which along with the other three temperaments, makes each individual unique. The temperaments colors for "core need" are: "Orange"—freedom, "Blue"— meaningful relationships, "Gold"— duty and responsibility or "Green"— knowledge and information.

"Once we realize our own core needs and understand what makes us tick, it becomes easier to view others through their core need and to understand how they process information and emotions. This enhances relationships, whether on the job, or in our personal life," said Esola.

The benefit of recognizing these interaction and temperament styles comes from understanding that when things are going well, when life is good, this is how I respond to the world. An added benefit is to recognize when things are not going well, or when we are in conflict, how our behavior, attitude and communication styles change to get that core need met. Some of those changes are less than positive and do not always serve us well. Esola refers to these as "shadow-side" behaviors.

"Spectrum training focuses on honest open dialogue and team building which are essential to the success of WRAMC's Department of Nursing in meeting its current mission and planning and setting its strategic direction for the success of future missions," said Horoho.

Thursday afternoon brought all 30 participants together for "Leadout," an interactive simulation activity in management skill. The land acquisition simulation exposes leadership skills, concentrates on team building and advances contributions to success while dealing with change and conflict. This high-energy, theory-applied activity can be used at all levels of an organization.

The participants were divided into three regional offices, chose a regional manager, and then following instructions, began acquiring land – at a cost. Dollar values apply to acquisition. You choose well and you make a profit. However, if land acquired does not meet standards, it costs. Observation showed that the groups, randomly chosen, strategized differently. One group began acquiring land immediately while another discussed choices in detail before making a move. The third played the game cautiously until the final minutes when they decided risk taking was their opportunity to win the game – and they were right!

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Nursing Staff Offsite Gets *Results (continued)*

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That's not to say that the land activity always went smoothly. During its course the company's focus changed as new guidance was introduced by senior management (Esola and Peters). Participants found themselves dealing with changes in leadership as new rules were applied. Changing the acquisition process and the company's goals seemed very much like daily life at WRAMC.

Changes were met with uncertainty, frustration, and at times, tempers flared. Members displayed resentment at the unfairness of changes delivered by senior management. Watching participants deal with the changes and their reactions as they worked through the activity it was obvious the varied temperaments handled the changes differently. Again, with the multitude of changes affecting WRAMC now and in the future, these senior nursing staff members were able to see and address their reactions to change and how they deal with it.

Such activity "gives one an understanding of different people's thought processes and why/how they may have come up with their courses of action. Also, this reminds one that not everyone thinks alike. This may be obvious, but we, even as leaders, get so involved in our day-to-day activities that we sometimes forget there are different ways to come up with a solution to a problem," said COL Elizabeth Johnson, Chief, Perioperative Nursing Service.

On Friday participants were given twenty minutes to gather thoughts from objectives established in September's session. Applying the eight steps to transforming your organization from the "Leading Change" John P. Kotter's Harvard Business Review article, and reviewing a questionnaire provided by Esola and Peters the participants critiqued the progress of their strategic nursing objectives. Had their work thus far measured up to the scrutiny? Could they see value in the current way of doing business, and if not, could they stop and make the necessary changes?

"By going back and scrutinizing their progress—what are their key milestones for the next 30–60 days, 60-90, 90-120 days— and then establishing a timeline for accomplishment "teams leveraged their efforts and focused on doing things that add value," said Esola.

The challenge to design a process and carry it through is a large one. But with change a daily way of life, closure of WRAMC and integration on the horizon change could prove to be monumental. "Change comes when all five objectives are heading in the same direction - something that keeps us unified. We have to look at what's changing, how things are working and change if change is needed," explained Peters.

The final exercise challenged participants to create a support systems map for their objective team. First, putting their objective in the middle of the map they were to identify the stakeholders or the business elements which supported that particular objective. "This is a way to challenge them to expand their support systems. We have a natural tendency to view our support system, be that personally or professionally, as less or more limited than it truly is," said Esola.

With stakeholders identified the challenge was to create support systems beyond what was initially considered. The next step was to recognize stakeholders that were shared across all of the objective teams. Teams realized new stakeholders that weren't initially seen as support and each viewed other objective teams as relational elements – such as morale and leadership – that could leverage their energy and work collaboratively.

The benefit to identifying relationships is more than recognizing the hierarchy. For success it needs to be lateral across the organization. Remembering this helps to break down barriers and silos that often exist in typical hierarchical organizations. We need to tap into the talents of others, not just our superiors and subordinates, to help us accomplish the mission.

"The team succeeded in introducing new members and succeeded in providing a framework of change for their nursing goals and objectives for WRAMC. They added a deeper level of fidelity to enable execution which will endure beyond transitioning leadership," said Esola.

A third session to continue the learning process is tentatively scheduled as an offsite in April 2007. At that time participants will review past objectives, set further goals and continue to challenge themselves to maintain processes of value.

"The importance of this training is that all of us are working basically in unchartered waters where we are making decisions that will impact how military healthcare will be delivered in the future in the NCA.

"These are exciting times and afford each of us the opportunity to be part of history; however for us to ensure that we are making the right decisions we have to ensure that we are openly and honestly dialoguing about the issues/concerns and impacts of each of our decisions. This can only be done by learning how we communicate with others, how we are perceived when we communicate and then understanding how our colleagues communicate," said Horoho. ■

Growing Pains: Military Healthcare In Transition from Great to Greater

By: Loretta M. Hobbs, MSOD

The vision of integration is

'one integrated health system and a world-class academic medical system that delivers the highest quality care, distinguished health professional education, and exemplary clinical and global research.'

This vision is undeniably awe-inspiring! Think of it— all branches of military service and the Uniformed Services University (USU), will benefit enormously. Those wounded, while in harms way, will likely benefit most. After all, integration is designed to take the best clinical practices from among all branches of service, as well as USU. The best minds from the Air Force, Army, Navy and USU will team together to promote and enhance research leading to state of the science healthcare delivery techniques and protocols, second to none in the entire world! Health professions education will be unsurpassed.

So, if this is the promise that military healthcare holds, then why do some feel a sense of loss, or feel skeptical, or even resistant? Isn't military healthcare of the future growing from great to greater— exponentially?

You may find yourself thinking -- yes, great vision, BUT— must the crown jewel of Army medicine, WRAMC, and the flagship of Navy medicine, NNMC, both have to be decommissioned in order to achieve this vision? Or since this means some level of change for everyone, who is going to protect and preserve our proud traditions; will they be sacrificed? Or how much are we (am I) expected to give, during this transition, in order to make this happen?

Such comments may be interpreted as resistant or ambivalent. The gestalt concept of change emphasizes that ambivalence is not only expected but also normal. Another interpretation may be that people are (1) trying to preserve the integrity of great institutions they cherish, and are (2) concerned about unanticipated consequences of dismantling the present state. These kinds of concerns, while present, can be especially difficult to give voice to in an environment where following orders is the norm, even when leaders genuinely encourage people to discuss them.

The Paradoxical Theory of Change, another gestalt concept, states that people need to experience what is, before recognizing all the alternatives of
what may be. This suggests that it is difficult (though not impossible) for persons or even institutions to move forward with change until the present state is fully experienced, cognitively and emotionally, and accepted.

Therefore, heightening concerns and conditions of the present support a quicker movement toward change than muting them. But how does all this apply to integration of NCA healthcare? It certainly provides a rational for why there are continual Town Hall meetings, focus groups, lots of committee meetings across the services and other informational settings where people are encouraged to discuss, ask questions, know about and contribute to the plans and process of integration.

Transition specialists, who track how humans experience change, note that worry, caution, fear, even grief are normal parts of transition, and at times can be wrenching. For example, William Bridges (1995) writes that humans typically experience three phases of transition (1) an ending, followed by (2) a period of confusion and distress, leading to (3) a new beginning. Nobel laureate, T.S. Eloit said it another way:

"What we call the beginning is often the end and to make an end is to make a beginning. The end is where we start from."

The National Capital Area (NCA) is now experiencing Bridges' second phase. We are clearly in the throes of a transition between an idea and the end state. Integration is emerging as a process of massive institutional change that excites some, distresses others, and challenging everyone. We are witnessing the birth of something new and birth is glorious, though painful. How, then, does one concentrate on the gloriousness of it all, amidst the contractions? Consider this:

Keep the vision of integration in range. If you believe that a world-class integrated healthcare system is a superior way to deliver care, then it is worth working through the challenges of the second stage of transition in some cases working through grief. If allowed, integration can be gratifying, but this will require accepting that there will be rough spots along the way. It means fighting for the highest quality of care, rather than fighting against change. It means accepting that every branch of U.S. military service has a great deal to contribute. It also means accepting that it might not be 'our way', but I can contribute to creating a better way.

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Have the courage to support the future. The Office of Integration has written:

> *Each military treatment facility will retain its original, primary military command. The new Walter Reed National Military Medical Center at Bethesda will still be Navy. The new, expanded DeWitt Community Hospital will be Army. And the other NCA healthcare facilities will also retain their primary Service affiliation.*

But what does this mean about my institutional culture and tradition? Well, integration is new and unchartered territory. The fact that no one has done this before in the NCA is indeed bold, and perhaps the greatest source of heartburn. This is because no one really knows what it will look like. There are no models or templates. We all know that a new, joint future does mean change, and change means that some practices, ways of working and doing business will be different.

As each department or division stands up, knowledge accumulates about how to do this in an environment of integration. An evolving mechanism is already in place to track, monitor and document both process and progress.

So yes, there will be a shift in the operational culture that will change the way things are done, change some structures and change the nomenclature. In fact, only true collaboration among healthcare personnel from the various services can result in a superior integrated system. While each Service will retain its identity, together all will build something new. But at the end of the day, the cultures of the Air Force, Army and Navy will remain.

Stay knowledgeable. Many people are working quite hard to provide current information across the NCA, about the changes and activities of integration. Updates are continually available on websites, in newsletters, through Office of Integration (OI) visits with NCA Commands and in other forms. Periodic Town Hall meetings offer an excellent opportunity to seek answers and offer opinions. In addition, information is occasionally sought through surveys, focus groups and questionnaires, as a way of listening widely to concerns and creating a feedback loop between all involved and those leading this effort.

Take advantage of the Office of Integration Organization Development resources. Organization Development Practitioners (ODPs) are process experts, skilled at working with people through organizational change. While there are many unknowns about the specifics of integration, there is a wealth of knowledge accumulated through research, scholarship and practice about the processes of change. ODP's standby ready to assist all Medical Treatment Facilities (MTFs) and USU with the change process, even as we focus the majority of our energy on the Medical Centers (MEDCENS). Below are some of the ways that ODPs serve the NCA integration effort.

Our main objective is to bolster resiliency at all levels of the NCA from a whole-system perspective. We keep the MEDCEN priority foremost in the context of the interrelation of all MTFs and USU in the NCA. An integrated NCA has to, therefore, be greater than any one of its parts.

We help build bridges between people and between Services to enhance effective teamwork, communication, coordination, working relationships, to keep a focus on the vision.

We assist leaders to clarify aspects of shifting organizational culture— a key element of our role. For example, clarifying differences in nomenclature and structure is critical to the functionality of integration.

ODP's assist change leaders to mitigate the effects of unexpected and emerging integration challenges.

We design and facilitate strategic planning offsites to support business planning practices of the NCA Commands that align their mission and their vision with the NCA integration initiative.

Finally, be confident that the United States Military Health System really can grow from great to greater—exponentially! Your confidence in the vision of integration is an essential, motivating element in a complex, and challenging process. In the climate of integration, confidence is as infectious as doubt. Therefore, we encourage you to be confident about and take pride in how contributions from the stellar practices of the Air Force, Army, Navy and USU will now join together to create the next generation of military healthcare. Lives depend on it! ■

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Design Plans Chosen for *New* Fort Belvoir Hospital

By: Jan Clark, PAO, Dewitt Health Care Network

As a sign of continued progress on the new Fort Belvoir community hospital, the major agencies responsible for planning and design met at the Community Center here Feb. 5 to 7.

Discussing the hospital site and design alternatives, the agencies represented included the Tricare Management Agency, Health Facilities Planning Agency, Corps of Engineers, command representatives from DeWitt hospital, Fort Belvoir Garrison and local integration and transition offices. Three potential design schemes by the architectural and engineering firm of HDR-Dewberry, generated spirited discussion among the more than 100 attendees.

DeWitt Commander, COL Canestrini, discusses chosen design for the new hospital at Ft. Belvoir
Photo: Jan Clark

In-depth discussion concentrated on patient and staff access, ease of movement through the facility, co-location of critical functions and the look and feel of the building's exterior.

Day one focused on the previously determined goals and objectives of building the premier military community hospital according to the Department of Defense stipulations. These are:

- Providing family centered, evidence-based 21st century care;
- Producing an on-time, on-budget, safe project; and,
- Protecting the local environment while blending with the Fort Belvoir community.

At the conclusion of day two, and following presentation and review of the three design schemes a consensus was reached. "While no one design met all expectations, the selection of Concept B, incorporating aspects from the other two designs, would best serve the needs of our community," said BRAC and Integration Chief, DHCN, Rick Repeta.

Members of HDR presented Maj. Gen. George W. Weightman, Commander, North Atlantic Regional Command, an overview of each design scheme during the final session Feb 7. MG Weightman discussed his concerns which included transportation and outpatient access, relocationing of the parking garages to better accommodate patients and redesigning the appearance to create spaces between outpatient structures allowing in more daylight.

MG Weightman agreed that Plan B was the best choice, with modifications stating, "Concept B is the most concentrated and easy to access of the plans and gives us a great building block to start with." Now that a concept has been chosen, work is to begin on refining those areas of concern. While those concerns are addressed, the Environmental Impact Statement (EIS) process is ongoing. ■

Are You Acronym Crazy?

Don't worry, we want to provide some clarity.

In a culture where acronyms are commonly used, new events such as the Base Realignment and Closure (BRAC) recommendations being made law by Congress, brings into existence more acronyms that typically make communicating in a culture like ours a little crazy.

Here we try to make sense of it all for you. Brace yourself, because a few of these may surprise you. This month you'll find meanings to some commonly used acronyms. ■

JCIDS– Joint Capabilities Integration and Development System
Definition:
The formal United States Department of Defense (DoD) procedure which defines acquisition requirements and evaluation criteria for future defense programs

JFHP– Joint Force Health Protection
Definition:
The continuum of programs across the Services to maintain health and to provide multiple layers of protection to all service members

JTF– Joint Task Force
Definition:
A DoD organization assigned to U.S. Northern Command to support federal law enforcement agencies in the interdiction of suspected transnational threats within and approaches to the continental United States

KACC– Kimbrough Ambulatory Care Center
Definition:
The U.S. Army Health Center located at Fort George G. Meade, Maryland that serves as the headquarters of the U.S. Army Medical Department Activity (MEDDAC)

MGMC– Malcolm Grow Medical Center
Definition:
A U.S. Air Force's ambulatory care center located on Andrews Air Force Base

MARCOM– Marketing and Communications
Definition:
The process that involves the coordination of diverse promotional vehicles that are strategically implemented at various times during a marketing campaign to ensure the message is consistently received the audience

MHS– Military Health System
Definition:
A one-of-a-kind organization that provides superlative medical support (preventative and resuscitative care) for the nation's over 9 million Soldiers, Sailors, Airmen, and Marines across the Services

MHSER– Military Health System Executive Review
Definition:
The committee with executive oversight over the Military Health System

MHS-OT–Military Health System Office of Transformation
Definition:
A senior executive level office that provides policy guidance and direction for units responsible for implementing base realignment and closure (BRAC) actions, medical readiness review initiatives, and local authorities working group recommendations

MILCON– Military Construction
Definition:
The organization that serves as the primary source for major construction and real property acquisition for the military services

MM– Market Manager
Definition:
A senior military officer given oversight and responsibility for developing a single, integrated business plan for the cross-service health system within the multi-service market in which they command

MRR– Medical Readiness Review
Definition:
The component of the Quandrennial Defense Review (QDR) that reviews the medical readiness posture and options for the future force structure

MSM– Multi-Service Market
Definition:
A geographical area in which more than one Service military treatment facility (MTF) is present and where significant beneficiary health care costs exist

MSMO– Multi Service Market Office
Definition:
The senior staff office that supports the Market Manager and Senior Market Managers

MTF– Military Treatment Facility
Definition:
A military hospital or clinic on or near a military base

RUMOR CONTROL: SO TRUE OR SO FALSE ???

SO FALSE

The integration of WRAMC and NNMC is dead

SO TRUE

MG Schoomaker has been named Commander of Walter Reed Army Medical Center

SO FALSE

The name for the new hospital at Fort Belvoir has been chosen

SO TRUE

The men and women of Walter Reed make it the *world-class* military treatment facility it is

SO FALSE

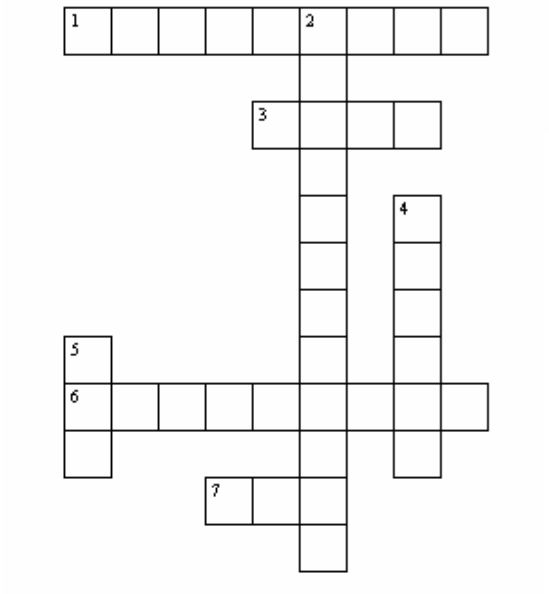
ODPs assist organizations with building bridges between people to create systemic change

Our Mission:
Force Health Protection

To meet and adapt to the evolving health care needs of our military force, our mission, as established by the Department of Defense, is to use preventive health techniques and emerging technologies in environmental surveillance and combat medicine to protect all service members before, during, and after deployment.

Force Health Protection is designed to improve the health of service members, prepare them for deployment, prevent casualties, and promptly treat injuries or illnesses that do occur, as well as care for their family members, and retirees and their families, who have served this great nation.

TRI-SERVICE CROSSWORD PUZZLE



ACROSS
1 Military Term: Combat boots with a capped toe
3 Military Term: One's Title
6 Navy Term: Title of the Captain in charge of a squadron of ships
7 Navy Term: Yes

DOWN
2 Navy Term: Really early in the morning
4 Army Term: New recruit or private
5 Military Term: Permanent Change of Station

ANSWERS FROM LAST MONTH:

ACROSS	DOWN
2 Fairy **3 Dixie Cup** **6 Army Brat** **8 Colonel**	**1 Cracker Jacks** **3 Dash Ten** **4 Bubba** **5 Basement** **7 Hop**

National Capital Area Military Health System

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THE FUTURE OF THE NCA MHS

Our Vision

We envision and are committed to *one* integrated health system which leverages the assets of all DoD health care treatment facilities in the National Capital Area.

The Tri-Service Walter Reed National Military Medical Center at Bethesda will be a world-wide military referral center and together with the Uniformed Services University of the Health Sciences (USU), will represent the core of this integrated health system.

All Tri-Service facilities in the NCA and the USU will serve as a premier academic medical system focused on delivering the highest quality care, distinguished health professional education, and exemplary clinical and translational research.